Supreme Court, U.S.
FILED

081533 MAR 9 - 2009

OFFICE OF THE CLERK
William K. Suter, Clerk

No. (1)

In The

Supreme Court of the United States

DANA LYNN MEHEN,

Petitioner,

vs.

DELTA AIRLINES, INC., et al.,

Respondents.

On Petition For A Writ Of Certiorari To The Ninth Circuit Court Of Appeals

PETITION FOR A WRIT OF CERTIORARI

DANA LYNN MEHEN
Pro Se
2968 N. Webster Rd.
Tucson, Arizona 85750
(520) 290-9067

QUESTIONS PRESENTED

The Plan is a dual-role ERISA plan fiduciary, which means that it both decides whether beneficiaries are eligible for benefits and pays any benefits it grants out of its own pocket. The Sixth Circuit Court of Appeals found the Long Term Disability Plan's denial of an employee's disability claim arbitrary and capricious in multiple respects. The questions presented are:

1. WHETHER THE COURT OF APPEALS ERRED IN CONCLUDING THAT DELTA'S DUAL-ROLE STATUS IS NOT A CONFLICT OF INTEREST OR SHOULD THIS COURT CONSIDER REVIEWING DELTA'S BENEFIT DENIAL.

2. IF A DUAL-ROLE INSURER IS DEEMED TO BE OPERATING UNDER A CONFLICT OF INTEREST, USING TAINTED EVIDENCE AND OTHER ERISA PROCEDURAL VIOLATIONS, THEN HOW SHOULD THAT CONFLICT BE TAKEN IN TO ACCOUNT IN JUDICIAL REVIEW OF A DISCRETIONARY BENEFIT DECISION AND WHAT PENALTIES MIGHT APPLY?

3. DOES AN AMERICAN CORPORATION/ EMPLOYER HAVE THE RIGHT TO THREATEN AND HARASS AN EMPLOYEE AND FAMILY MEMBERS SIMPLY BECAUSE THE EMPLOYEE IS PURSUING JUSTICE THROUGH THE COURT SYSTEM, AND IF NOT, THEN WHAT PENALTIES SHOULD APPLY?

PARTIES TO THE PROCEEDINGS

The parties to the proceedings are the Respondents-Defendants: Delta Airlines, Inc.; Delta Family-Care Disability and Survivorship Plan; Delta's self-insured United Healthcare insurance; Delta Administrators: Mr. Mullins, Ms. Wibbens, Mr. Piper, Mr. Young, Ms. Frazier, Ms. Hord, Cobra Administrator, Mr. Heilmann; Delta Attorney: Mr. King; Delta Company Doctors, Salam Alkasspooles, M.D., James O'Brien, M.D., Delta Private Investigator, DDI Company; Mr. Pat Higgins and Petitioner Dana Lynn Mehen.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
LIST OF PARTIES	ii
TABLE OF CONTENTS	iii
TABLE OF AUTHORITIES	vi
OPINIONS BELOW	1
JURISDICTION	1
STATUTORY PROVISIONS INVOLVED	2
STATEMENT OF THE CASE	6
REASONS FOR GRANTING THE WRIT	17
I. A DUAL-ROLE INSURER OPERATES UNDER A CONFLICT OF INTEREST THAT A COURT SHOULD CONSIDER IN REVIEWING BENEFIT DECISIONS	17
A. As This Has Held, Congress Did Not Prescribe How To Review The Decisions Of A Dual-Role Insurer, But Trust Law Provides The Answer	18
B. This Court Correctly Concluded That, Under Trust Law, A Fiduciary's Authorized Conflict Of Interest Must Be Weighed As A Factor In Reviewing The Fiduciary's Decision	20
II. A COURT REVIEWING A DUAL-ROLE INSURER'S BENEFIT DENIAL SHOULD REQUIRE "CAREFUL SCRUTINY" AND DIMINISHED DEFERENCE AS EACH CASE WARRANTS	21

TABLE OF CONTENTS – Continued

Page

A. Deference To A Dual-Role Insurer Should Decline As Scrutiny Exposes Additional Reasons To Suspect That The Conflict May Have Affected The Insurer's Decision 24

B. As This Court Has Held A Claim Administrator Must Specifically Consider A Bare Determination Of The Social Security Administration Which Must Be Considered By An ERISA Administrator 26

C. The New Case Law Standard Should Be Applied Invoking A *De Novo* Standard Of Review Which Will Require An Alternate Conclusion 27

CONCLUSION 29

APPENDIX

Ninth Circuit Court Of Appeals Denial, Not For Publication Memorandum dated October 24, 2008 ..... App. 1

United States District Court For The District Of Arizona, Final Judgment, Denial and Voluntary Dismissal Of Defendants Counterclaim dated June 15, 2006 ..... App. 5

United States District Court, District Of Arizona, Judgment In A Civil Case, Defendants Counterclaim Dismissed With Prejudice dated May 18, 2006 ..... App. 7

TABLE OF CONTENTS – Continued

Page

United States District Court For The District Of Arizona, Order, Defendants Counterclaim Dismissed With Prejudice dated May 11, 2006.....App. 8

Ninth Circuit Court Of Appeals Denial Of The Petition For Rehearing dated December 11, 2008 .....App. 9

TABLE OF AUTHORITIES

Page

FEDERAL CASES

Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955 (9th Cir. 2006) (en Banc).....25, 26

Aetna Health Inc. v. Davila, 542 U.S. 200 (2004).....18

Armstrong v. Aetna Life Ins. Co., 128 F.3d 1253 (8th Cir. 1997).....18

Bennett v. Unum Life Ins. Co. of Am., 321 F. Supp. 2d 925 (E.D. Tenn. 2004).....17

Brigham v. Sun Life of Can., 317 F.3d 72 (1st Cir. 2003).....23

Brown v. Blue Cross & Blue Shield of Alabama, Inc., 898 F.2d 1556 (11th Cir. 1990).....17

Bruch v. Firestone Tire & Rubber Co., 828 F.2d 134 (3d Cir. 1987), *aff'd in part, rev'd in part on other grounds*, 489 U.S. 101 (1989).....4, 13, 19, 21, 25

Buffonge v. Prudential Ins. Co. of America, 426 F.3d 20 (1st Cir. 2005).....7

Castello v. Gamache, 593 F.2d 358 (8th Cir. 1979).....28

Dabertin v. HCR Manor Care, Inc., 373 F.3d 822 (7th Cir. 2004).....24

De Nobel v. Vitro Corp., 885 F.3d 1180 (4th Cir. 1989).....17

TABLE OF AUTHORITIES – Continued

Page

Doe v. Group Hospitalization & Med. Services, 3 F.3d 80 (4th Cir. 1993) 23

Ellis v. Metro. Life Ins. Co., 126 F.3d 228 (4th Cir. 1997) 24

Fought v. Unum Life Ins. Co. of America, 379 F.3d 997 (10th Cir. 2004) 25

Glenn v. Metro. Life Ins. Co., 2007 U.S. Dist. LEXIS 1421 (S.D. Ohio Jan. 8, 2007) 28

Glenn v. Metro. Life Ins. Co., Supreme Court No. 06-923 (June 19, 2008) ..... *passim*

Ladd v. ITT Corp., 148 F.3d 753 (7th Cir. 1998) 25

Lang v. Long-Term Dis. Plan of Sponsor Applied Remote Tech., Inc., 125 F.3d 794 (9th Cir. 1997) 24

Mass. Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985) 19

Patterson v. Shumate, 504 U.S. 753 (1992) 27

Post v. Hartford Ins. Co., 501 F.3d 154 (3rd Cir. 2007) 22

Radford Trust v. First Unum Life Ins. Co. of America, 321 F. Supp. 2d 226 (D. Mass. 2004), *rev'd in part on other grounds*, 491 F.3d 21 (1st Cir. 2007) 17

Saffle v. Sierra Pacific Power Co., 85 F.3d 455 (9th Cir. 1996) 18

Salley v. E.I. Dupont de Nemours & Co., 966 F.2d 1011 (5th Cir. 1992) 18

TABLE OF AUTHORITIES – Continued

Page

Schatz v. Mutual of Omaha Ins. Co., 220 F.3d 944 (8th Cir. 2000) 27

Shaw v. Delta Airlines, Inc., 463 U.S. 85 (1983) 19

Stup v. Unum Life Ins. Co. of America, 390 F.3d 301 (4th Cir. 2004) 24

Van Boxel v. Journal Co. Employees Pension Trust, 836 F.2d 1048 (7th Cir. 1987).....24

White Mountain Apache Tribe v. United States, 249 F.3d 1364 (Fed. Cir. 2001), *aff'd*, 537 U.S. 465 (2003).....19

Woo v. Deluxe Corp., 144 F.3d 1157 (8th Cir. 1998).....26

Wright v. R.R. Donnelly & Sons Co. Group Benefits Plan, 402 F.3d 67 (1st Cir. 2005).....24

STATE CASES

Armington v. Meyer, 236 A.2d 450 (R.I. 1967).....19

Clement v. Larkey, 863 S.W.2d 580 (Ark. 1993) 25

Copp v. Worcester County Nat'l Bank, 199 N.E.2d 200 (Mass. 1964).....24

Garvey v. Garvey, 22 N.E. 889 (Mass. 1889) 20

In re Buchar's Estate, 74 A. 237 (Pa. 1909) 20, 25

In re Estate of Gilliland, 140 Cal. Rptr. 795 (Ct. App. 1977) 20

In re Estate of McCart, 847 P.2d 184 (Col. Ct. App. 1992) 20

TABLE OF AUTHORITIES – Continued

Page

In re Heller, 849 N.E.2d 262 (N.Y. 2006) 20

In re Peabody's Will, 96 N.Y.S.2d 556 (Sup. Ct. 1950), *aff'd*, 98 N.Y.S.2d 614 (App. Div. 1950) 19

Mesler v. Holly, 318 So.2d 530 (Fla. App. 1975) 20

FEDERAL STATUTES

28 U.S.C. § 455(b)(4) 2

28 U.S.C. § 1254(1) 2

29 U.S.C. § 502(c)(a)(1)(A) 28

29 U.S.C. § 1001 5

29 U.S.C. § 1002/1003 1

29 U.S.C. § 1024(b)(4) 28

29 U.S.C. § 1104(a)(1)(A) 3, 22

29 U.S.C. § 1108(1)(c)(3) 4, 18, 21

29 U.S.C. § 1132(a)(1)(B)(g) 2, 16, 21, 23

29 C.F.R. § 1601.01(e) 4, 28

29 C.F.R. § 1604.01(e) 28

OTHER AUTHORITIES

COBRA 5, 7, 11

ERISA of 1974 .....*passim*

H.R. 1592 Mathew Shepard Act 2007 .....6, 28

Americans With Disabilities Act 1990 .....4, 15

www.welcomeaboardtoxicairlines.com 8

TABLE OF AUTHORITIES – Continued

Page

G. COUCH, R. ANDERSON, & M. RHODES, COUCH ON INS. 2D (rev. ed. 1984) 19

AUSTIN SCOTT & WILLIAM FRATCHER, THE LAW OF TRUSTS (4th ed. 2001).....18

GEORGE BOGERT ET AL., THE LAW OF TRUSTS & TRUSTEES (rev. 2d ed. 1993).....18

John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315 (2007).....17, 18

Kathryn Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083 (2001).....24

Major League Baseball Rules 21(d) 17

Peter G. Gosselin, *The New Deal: The Safety Net She Believed In Was Pulled Away When She Fell*, L.A. Times, Aug. 21, 2005 18

PETER J. WIEDENBECK, ERISA IN THE COURTS (2008) 26

RESTATEMENT (SECOND) OF TRUSTS § 187 (1959) 13, 21

RESTATEMENT (THIRD) OF TRUSTS § 37 (2001).....22

RESTATEMENT (THIRD) OF TRUSTS § 37 (2005).....22

Unum Group Swings to Profit from Quarterly Loss; Claims Reassessment 'Substantially Completed', BEST WIRE (Nov. 1, 2006).....26

PETITION FOR A WRIT OF CERTIORARI

The Petitioner, DANA MEHEN, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit, entered in *Dana Mehen v. Delta Airlines, Inc. et al.*, No. 06-16388 Order October, 24, 2008, Panel Re-hearing December 11, 2008.

OPINION BELOW

The decision of the Ninth Circuit is reported at *Mehen v. Delta Airlines, Inc., et al.*, No. 06-16388 (9th Cir. 2008). U.S. District Court of Arizona No. CV-02-00595-CKJ.

JURISDICTION

This petition seeks review of the judgment entered by the United States Court of Appeals for the Ninth Circuit, the Panel Rehearing Order denied December 11, 2008 in the matter of *Mehen v. Delta Airlines, Inc., et al.* This Court has jurisdiction over this matter pursuant to 29 U.S.C. § 1132. Delta Airlines, Inc., et al., has an ERISA employee benefit plan as defined by 29 U.S.C. § 1002/1003. The jurisdiction of this Court to review the judgment of the United States

Court of Appeals for the Ninth Circuit is invoked under the Title 28, United States Code § 1254(1).

STATUTES AND REGULATIONS INVOLVED

28 U.S.C. § 455

> (b) He shall disqualify himself in the following circumstances (4) He knows that he, he individually or as a fiduciary, or his spouse or minor child residing in his household, has a financial interest in the proceeding or any other interest that could be substantially affected by the outcome of the proceeding.

29 U.S.C. § 1132 Civil Enforcement

> Persons empowered to bring civil action. A civil action may be brought (1) by a participant or beneficiary.(A) for the relief provided for in subsection (c) or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan or to clarify his rights to the future benefits under the terms of the plan. As part of reform of employee benefits law, Congress enacted ERISA and placed emphasis on employer's or other plan sponsor's obligations to provide information about the employee benefits. One aspect of this is the duty of a plan administrator to respond to written requests for information. ERISA 502(c), 29 U.S.C. § 1132(c) provides for penalties for an administrator's refusal to supply required

information. Under that section of ERISA, (1) Any administrator . . . [who fails to provide certain information] [1] . . . (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 [2] a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

29 U.S.C. § 1104 Fiduciary Duties

(a)(1) Subject to Sections 1103(c)(d) and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the participants and beneficiaries and

(A) for the exclusive purpose of: (i) Providing benefits to participants and their beneficiaries and (ii) defraying reasonable expenses of administrating the plan.

29 U.S.C. § 1108(1)(c)(3)

> (1) Protective of the rights of the participants or beneficiaries of such plan, (c)(3) Serving as fiduciary in addition to being an officer, employee, agent or other representative of a party of interest.

489 U.S. at 101, 102, 113, 115

> De novo is the appropriate standard of review for denial of benefits. Under Arbitrary and Capricious standard, a district court will uphold a plan administrator's interpretation of a plan if it is reasonable, unless the plan administrators decision was without reason, unsupported by substantial evidence, or erroneous as a matter of law.
>
> A benefit plan gives discretion to an administrator or fiduciary who operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion, thus the default Standard of Review is de novo Standard of Review.

C.F.R. § 1601.01(e)

> The employer can be held liable for harassment if the employer knew of the harassment and failed to stop harassment.

ADA 1990

> Americans with Disabilities Act of 1990, Prohibits private employers, state, local government, government agencies, and labor

unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions and privileges of employment.

COBRA

Consolidated Omnibus Budget Reconciliation Act gives workers and families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as, voluntary or involuntary job loss, reduction of hours worked, transition between jobs, death, divorce and other life events.

ERISA

29 U.S.C. § 1001, Employment Retirement Income Security Act of 1974, Pub. L. 93-406, 88 Stat. 829 enacted September 2, 1974, is an American Federal Statue that established minimum standard for pension plans in private industry and provides for extensive rules of the Federal Income Tax effects of transactions associated with employee benefit plans. ERISA was enacted to protect the interests of the plan participants or their beneficiaries by requiring the disclosure to them of financial and other information concerning the plan; by establishing the standard of conduct for the plan fiduciary; and providing for appropriate remedies and access to the federal courts.

HIPPA

> Health Insurance Portability and Accountability Pub. 104-191 was enacted August 21, 1996. HIPPA amended ERISA to provide for improved portability and continuity of Health Insurance Coverage connected with employment, among other things.

H.R. 1592

> Mathew Shepard Act Local Law Enforcement Hate Crime Prevention Act 2007 (1) the term "crime of violence" has meaning given that term in Sec. 16, Title 18, U.S.C. (2) The term "hate crime" has the meaning given such term in Sec. 280003(a) of the Violent Crime Control and Law Enforcement Act of 1999(c) Is motivated by prejudice based on the actual or perceived race, color, religion, national origin, gender, sexual orientation, gender identity or disability of the victim or is a violation of the State, Local, Tribal, hate crime laws.

STATEMENT OF THE CASE

With all due respect for the Court, I, Dana Mehen respectfully request a petition for Certiorari, because the Ninth Circuit Appeals Court ruling in my case is in conflict with the new current ruling in Supreme Court case *Glenn v. Metro. Life Ins. Co.*, Supreme Court No. 06-923 (June 19, 2008). Also, to be considered is the Mathew Shepard Act H.R. 1592

2007 new information which encompasses the harassment directed toward a disabled person a hate crime. I ask for all protections afforded by the Americans with Disabilities Act laws. I respectfully ask for reconsideration with this Writ of Certiorari. The issues presented for consideration are a case of an ERISA appeal, of denied benefits, also it is a question of whether an American corporation has the right to harass its workers. Did my former employer have the right to harass, stalk and implicitly threaten myself and family because I became disabled as a result of my employment with the respondent? I feel that they did not have this right. It would appear that the District and Appeals Courts have not addressed the "dual-role" conflict of interest, abuse of discretion and breach of fiduciary duty or considered the Social Security Administration rating of disability that Mehen has continually held since January 1996 and the continual disabled opinion of my treating doctor, a toxicologist and occupational medicine expert in this particular field. The Plan administrator's opposite decision after Mehen's SSA disability rating is to now rule that Mehen is not disabled, in order to terminate Mehen's benefits, with the help of the company doctors that respondents hired to write "mischaracterizations of the medical record", *Buffonge v. Prudential Ins. Co. of America*, 426 F.3d 20, 31, n.15 (1st Cir. 2005) and completely ignoring Mehen's disability status with SSA or the ERISA and COBRA statutory violations, which is contrary to ERISA laws and requirements for "full and Fair review". In which a *de novo* standard of review

should have applied. Nor did the courts address the harassment campaign that has been directed at our family because I choose to pursue my rights under the laws of the United States of America, as an American citizen. False surveillance video was used to terminate Mehen's benefits. With the recent ruling of the case *Glenn v. Metropolitan Life Insurance Company*, Supreme Court, No. 06-923 (June 19, 2008), I respectfully ask the Court to issue the Writ because of the similar issues and new rulings presented in *Glenn v. Metropolitan Life Insurance Company*. I pray that the Court will provide justice, we have endured a severe hardship without medical benefits and as family have risked our lives to seek justice in this matter, believing in the American judicial system.

Petitioner Mehen was a loyal and dedicated employee of the defendants with an exceptional administrative record. During the course of this employment I became permanently disabled. I suffer from chemical toxicity non-pharmacological. Recently being labeled "Aero Toxic Disease" because of the increased numbers of crewmembers falling ill with this same disease, exposure to the toxic fumes onboard the aircraft. Reference www.welcomeaboard toxicairlines.com. My condition amounts to a chemically induced version of AIDS. I have no immune system. This diagnosis is not my own. I did not suddenly decide to become disabled as the defendants would like you to believe to remove their own culpability in this matter. I have been in the care of a respected and licensed toxicologist specialist in the

field of occupational medicine, for the past twelve years, Michael R. Gray, MD. There has never been any conflict with respect to my diagnosis. As part of the LTD program I was forced to visit physicians not of my own choosing, company doctors that were paid for by the defendants. Any and all reports by these physicians paid for by the defendants must be viewed as suspect, especially the changed medical report by Dr. Alkasspooles, MD. My own doctor has never wavered on my disability diagnosis. Mehen was required by the Delta Plan administrators to apply for SSA benefits in July 1995 and was awarded in January 1996. Mehen has the Social Security Administration disability rating since January 1996 and all SSA reviews since that time has labeled Mehen as disabled. Mehen has remained "continuously disabled within the meaning of the Plan language" not eligible for any gainful employment. The Plan was notified concerning my SSA award by U.S. Postal certified mail. The certified mail record was entered into evidence. I signed all releases for the Plan administrators to access all SSA records and all medical information. In addition, I cooperated with any and all Plan requests.

Because of my disabled condition I was targeted by my employer for dismissal. The medical benefits that I had earned through the course of my twenty year employment were effectively stopped September 1, 2000. Although Mehen appealed, all administrative remedies were exhausted and denied. My medical bills went unpaid, my credit was ruined, I was dismissed

from the program along with my family members. My minor daughter was struggling with a kidney disease first diagnosed in 1995. In my time of need the benefits that I had worked so hard for were denied me.

I was dismissed from the program because the respondents on June 29, 1999 surveyed my husband and two minor children claiming that the elder child (15 yr. old) was me. While employment law dictates that it is acceptable to use surveillance of an employee in a public place, I was NOT in the surveillance video. The law does not provide for the harassment of family members in this quest and the harassment remains ongoing to date because Mehen has pursued her rights in court. June 13, 2003, we caught the man harassing our family at night, he crashed into our gate and fence; it was the same man that delivered legal papers by day for the respondents' local attorneys Lewis/Roca, One South Church Ave., Tucson, Arizona 85701. This man along with other operatives are still harassing our family although we have made numerous complaints to the Pima County Sheriff's dept. and the FBI, this harassment is ongoing. We have experienced harassing telephone calls all night, break-ins to our home and autos, smashed windshields, dented car fenders, continually followed, run off the road, prowling at our home, acts of vandalism at our home, stolen mail, smashed mailbox, nails in the driveway causing flat tires, and recent incident I was run off the road on 1/17/2009. Furthermore, the harassment is also directed at my 81 yr. old widowed Mother, Alice

Mehen and the others who signed the witness affidavits to enter into District Court, have all experienced some form of harassment and threats.

After being ousted from the long term disability benefits program I was forced to enroll in COBRA. My payments were rejected, my checks were sent back. The U.S. Department of Labor Ms. Gloria Polk forced the Respondents to reinstate Mehen to the COBRA Plan and still the medical bills remained unpaid. Ms. Polk referred Mehen to HIPPA (national health insurance coordinator) where it was determined that Mehen's employment was listed by Delta Airlines as "terminated". Mehen went to the EEOC, was issued the "right to suit" with the basis being discriminatory for denial of benefits and termination of employment. Delta quickly reversed the termination attempt. Upon receiving medical services ordered by my doctors, the institutions were told repeatedly "Mehen has no insurance coverage" although all payments to COBRA were paid and current. After a piecemeal enrollment in the program for approximately one year I applied and was qualified to receive an extension of coverage because I am a person with a recognized disability according to the Social Security Administration. My family and myself were unlawfully denied the COBRA extension. I did notify the Plan about my disability as required by certified mail. A copy of the certified mail record was submitted as evidence.

Petitioner Dana Mehen was employed by Delta Airlines Inc. for approximately twenty years before

she became permanently disabled as a result of her employment with Delta Airlines where she was exposed to toxic chemicals onboard the aircraft, jet exhaust, jet fuel, smoke fume events, oil/lubricants, de-icing fluid, hydraulic fluid, DDT pesticides and other toxic chemicals all a part of regular commercial airline operations.

Mehen has at all times since going on medical leave from Delta Airlines been totally disabled. She has continually been affirmed 100% disabled by the Social Security Administration. Mehen was an excellent employee with many letters of commendation from Delta Airlines, the public and fellow co-workers.

As a disabled employee Mehen applied for benefits through the Delta Long Term Disability Plan which she received. Although Mehen has remained fully disabled at all times under the Long Term Benefits Program (hereafter the Plan) Mehen was subject to harassment and the constant fear that her desperately needed medical benefits would be terminated. The process to retain medical benefits under this program can be viewed as nothing but arbitrary and capricious. The Plan required Mehen to attend hostile doctor's visits paid for by her employer. The opinions of these doctors could be used to usurp the formal and repeated diagnosis of Mehen's long term physician. In sum the opinion of a doctor paid for by the Plan, a visit that in some cases involved no examination, and the opinion of a doctor who was not a specialist in the area of Mehen's disability could override the findings of her long term care provider

who is a noted specialist in the field of toxicology. Mehen was disabled by toxic chemical exposures on the aircraft which resulted in systematic and total immune failure. Mehen's condition is similar to patients suffering the effects of the AIDS/HIV virus with no available cure.

These practices, by the Plan to systematically and inexplicably ignore critical evidence, reverse positions, and reject the consistent opinion of an examining Physician in favor of consultants who reviewed a cold paper record speaks to the failure of fiduciary duty that exist within these dual-role trusts.

The Supreme Court's direction in *Bruch v. Firestone Tire & Rubber*, 828 F.2d 134 (3d Cir. 1987), *aff'd in part, rev'd in part on other grounds*, 489 U.S. 101 (1989), that such a dual role "conflict *must* be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" (quoting RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959) ("SECOND RESTATEMENT") (emphasis added)). The rulings in Mehen's case so far have neglected to follow this direction.

Mehen becomes totally disabled

After years of medical treatment for a plethora of symptoms: Immune failure, Toxic Encephalathapy, Neurological damage, Brain Lesions (myelin in blood) MS, Lupus, Chronic Fatigue, Brain Injury, severe headaches brought on by brain swelling, mental confusion, memory trouble, vision changes, photophobia, Fibromyalgia, Large/Small airways disease,

Asthma, viruses brought on by failed immune Eppstein-barr, CMV, #6, open sores that never heal due to viruses, ear infections and abnormalities, incontinence, loss of bowel control, Chronic Upper Respiratory Infections, lymph swelling and continual infections, testing for lymphoma, abdominal tumors, Supplemental Oxygen needed, loss of use of left side limbs indicating possible stroke, muscle weakness, Hypertension uncontrollable, Pain on a daily basis, Depression, and recently severe diabetes. No such health problems in Mehen's family history. Mehen was healthy and athletic before this illness struck. Mehen has been continuously disabled since 1994. Mehen is unable to leave her bed for months after using all of her sick time and short term disability benefits. Mehen goes on to Long Term Disability December 1994. At all times Mehen was eligible to be a participant in the Plan. The only stipulation of the Delta Family-Care Plan was that Mehen remain continuously disabled which she has done, is disabled to this date, which is documented by her treating physicians and maintains the Federal Social Security Disability rating.

Delta forces Mehen to apply for Social Security benefits

July 1995 the Plan administrators tell Mehen she will not receive any more Plan benefits until she applies for SSA. She was awarded Social Security benefits on the first evaluation by SSA doctors.

Mehen is awarded Social Security benefits

January 1996 Mehen has retained this federal rating from this time forward. Mehen is a "Qualified" individual as defined by the Social Security Administration and the ADA, whose life has been dramatically affected in more than four major areas of life such as walking, breathing, sleeping and standing. She is 100% disabled with a poor prognosis. September 1, 2000 received a letter terminating her benefits. She was no longer entitled to benefits from the Delta Family-Care Plan as she did not meet the stringent definition of the Plan which states "that the employee must remain continuously disabled". After forcing Mehen to pursue her Social Security benefits and ceding that she is totally disabled by continuing her benefits following the Social Security decision, the Plan then began to require Mehen to attend multiple hostile doctor's visits in attempt to reverse the SSA and treating doctor's diagnosis of disabled.

Termination of Benefits

After visiting more than 24 doctors there were only two hostile doctors who doubted Mehen's condition in any regard. Salam Alkaspooles, MD, gave an initial disabled report (June 1999) then changed the report one year later to say not disabled: James O'Brien, MD. Both reports lead to the termination of Mehen's benefits. Both company doctors paid for by the Delta Plan.

James O'Brien MD is a psychiatrist for the Medical Consultants Network. He made the determination that Mehen was *physically* able to go back to work. "Claimant (Mehen) had a history of missing work for dubious reasons for instance Maternity Leave".

Salam Alkasspooles, MD wrote a report in June 1999 after examining Mehen, stating that in his professional opinion Mehen was disabled and would need to be re-evaluated in six months to see if her disabled condition might change. In July 2000 more than a year and without any re-examination he wrote the addendum stating "she can work". Common sense and personal integrity would not allow a physician to make a determination about a patient without examining the patient in person. Along with the FALSE surveillance video of June 29, 1999 of Mehen's husband and two minor daughters, respondents terminated Mehen's benefits.

Delta Persists in Denial, Ignoring Key Medical Information and the SSA Ruling

The Plan held the decisions of these two doctors above the prevailing consensus, the decision of the Social Security Administration and the diagnosis of Mehen's treating physician a specialist in the field of toxicology, occupational medicine and her primary care physician. After exhausting all administrative remedies, Mehen files suit in Federal Court for benefits owed to her under 29 U.S.C. § 1132(a)(1)(B).

REASONS FOR GRANTING THE PETITION

I. A DUAL-ROLE INSURER OPERATES UNDER A CONFLICT OF INTEREST THAT A COURT SHOULD CONSIDER IN REVIEWING BENEFIT DENIALS.

One cannot depend upon the dual-fiduciary to be self regulating. Businesses will time and time again seek to enhance profit. This creates an inherent conflict of interest that cannot be surmounted to create a true fiduciary. *Metropolitan Life Ins. Co. v. Glenn*, Supreme Ct., 06-923, June 19, 2008. Other examples, 28 U.S.C. § 455(b)(4), Major league baseball rules 21(d), Delta LTD Plan, "is exercising discretion over a situation for which it incurs direct, immediate expense as a result of benefit determinations favorable to the Plan participants." *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1561 (11th Cir. 1990) (quoting *De Nobel v. Vitro Corp.*, 885 F.2d 1180, 1191 (4th Cir. 1989). That is the classic definition of an "economic conflict of interest by a fiduciary," under trust law and common parlance. See John H. Langbein, Trust Law as Regulatory Law: *The Unum/Provident Scandal and Judicial Review of benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315 (2007) (documenting the scandal), *Bennett v. Unum Life Ins. Co. of Am.*, 321 F. Supp. 2d 925, 933 (E.D. Tenn. 2004), *Radford Trust v. First Unum Life Ins. Co. of Am.*, 321 F. Supp. 2d 226, 247 & n.20 (D. Mass. 2004), *rev'd in part on other grounds*, 491 F.3d 21 (1st Cir. 2007). In the *MetLife* case regulators concluded that the conflict of interest could

have tainted as many as 200,000 claim denials. As the California Insurance Commissioner observed "this not just an Unum Provident problem, it's an insurance industry one". See Peter Gosselin *The New Deal: The Safety Net She Believed In Was Pulled Away When She Fell*, L.A. Times, August 21, 2005. The National Asso. of Insurance Commissioners agrees. See NAIC Br., Prof. Langbein, 101 Nw. U.L. Rev. at 1321-22 & n.41, GEORGE BOGERT ET AL., THE LAW OF TRUSTS & TRUSTEES 543 (rev. 2d ed. 1993), AUSTIN SCOTT & WILLIAM FRATCHER, THE LAW OF TRUSTS 107.1 (4th ed. 2001). Other cases, *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997). As this Court has emphasized, a "benefit determination under ERISA. . . . is generally a fiduciary act," *Aetna Health Inc. v. Davila*, 542 U.S. 200, 218 (2004); *Saffle v. Sierra Pacific Power Co.*, 85 F.3d 455 (9th Cir. 1996); *Salley v. E.I. Dupont de Nemours & Co.*, 966 F.2d 1011, 101.

A. As This Court Has Held, Congress Did Not Prescribe How to Review the Decisions of a Dual-Role Insurer, but Trust Law Provides the Answer.

I. Everyone agrees the most explicit statement Congress made about dual-role fiduciaries is this: ERISA should not be construed "to *prohibit* any fiduciary from . . . serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest." 29 U.S.C. § 1108(1)(c)(3) (emphasis added). As The Plan acknowledges, this

provision "*authorizes*" the dual role. All that means is that the conflict is *not illegal*. Pet'r 21, 22. Congress did not, however, say anything about how courts should defer to an insurer operating under such a conflict. In fact, in *Firestone*, this Court held that ERISA says nothing at all about standards of review for benefit denials. There, this Court adopted *de novo* review as the default standard in ERISA cases. 489 U.S. at 115. The *de novo* standard of review needs to be applied in this matter. ERISA was enacted "to promote the interests of employee benefit plans and to protect contractually defined benefits." *Shaw v. Delta Airlines Inc.*, 463 U.S. 85, 90 (1983), *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985). In the pre-ERISA world, employees had the right to bring state-law contract claims for the denial of promised benefits and those claims would be subject to *de novo* review and any contractual ambiguity would have resolved against the insurer. G. COUCH, R. ANDERSON, & M. RHODES, COUCH ON INS. 2D 15:83, at 399 n.4 (rev. ed. 1984) (citing cases from the District of Columbia and 47 states, with no contrary authority). These protections shielded the employee from any possibility that the insurer's profit motive would affect any decision. See trust cases: *Armington v. Meyer*, 236 A.2d 450 (R.I. 1967), *White Mountain Apache Tribe v. United States*, 249 F.3d 1364, 1379 (Fed. Cir. 2001) (the Court must be careful in scrutinizing actions of a conflicted trustee), *aff'd* 537 U.S. 465 (2003); *Peabody's Will*, 96 N.Y.S. 2d 556, 561 (Sup. Ct. 1950) (when a trustee operates under an authorized conflict, "his conduct in

administering the trust will be more closely scrutinized"), *aff'd* 98 N.Y.S.2d 614 (App. Div. 1950), *Heller*, 849 N.E.2d 262-66 (N.Y. 2006) ("scrutinized by the courts with special care"); *Messler v. Holly*, 318 So.2d 530, 533 (Fla. App. 1975) (conflicted trustee's decision becomes particularly vulnerable to a challenge by other beneficiaries); *In the Estate of McCart*, 847 P.2d 184, 185-187 (Col. Ct. App.1992) (applying close scrutiny to conclude that trustee-beneficiary abused discretion), *In Buchar's Estate*, 74 A. 237, 238 (Pa. 1909) (same); *Garvey v. Garvey*, 22 N.E. 889, 890 (Mass. 1889) (same); *In the Estate of Gilliland*, 140 Cal. Rptr. 795, 802 (Ct. App. 1977).

B. This Court Correctly Concluded That, Under Trust Law, a Fiduciary's Authorized Conflict of Interest Must Be Weighed as a Factor in Reviewing the Fiduciary's Decision.

I. This case presents an obvious conflict of interest. As a dual-role insurer the Plan has a financial stake in every claim for benefits that is submitted under the plan. There is nothing "potential" about the Plan's financial interest. Every time the Plan concludes that a claimant is entitled to benefits under the plan, it must reach into its own pocket and pay those benefits. Conversely, every time the Plan denies a claim, it saves the money it would have paid the employee – as it did with Mehen. *Metropolitan Life Ins. Co. v. Glenn*, Supreme Ct., 06-923, June 19, 2008. Nevertheless, the Plan insists that a court is forbidden

even to consider the conflict in reviewing a benefit denial under 29 U.S.C. § 1132(a)(1)(B). Most circuits disagree with The Plan's position. That is because The Plan's position finds no support in ERISA or its underlying policies, in this Court's precedent, or in trust law. ERISA does not prohibit a court from weighing a dual-role conflict when reviewing a benefit denial claim. All ERISA says is that it will not "*prohibit* any fiduciary" from serving a dual role. 29 U.S.C. § 1108(1)(c)(3) (emphasis added). As this Court held in *Firestone*, Congress said nothing about how courts should scrutinize a benefit denial. Rather, ERISA imports trust law to define the standard of review. Trust law says exactly what this Court observed in *Firestone*: When a trustee operates under a conflict of interest, "that conflict *must* be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting SECOND RESTATEMENT § 187, cmt. d (emphasis added)).

II. Review of the Decisions of a Dual-Role Insurer Must Require Careful Scrutiny

In fact, trust law speaks directly to the questions presented. The most explicit statement in the most current and definitive distillation of trust law describes how courts should account for a bare conflict: Whenever bare "conflict-of-interest situations exist" – i.e., even when there is no additional evidence that the conflict affected the fiduciary's decision – "the conduct of the trustee in the administration of the trust will be subject to *especially careful scrutiny.*"

RESTATEMENT (THIRD) OF TRUSTS § 37, cmt. f(1) (2001), (2005) (emphasis added) ("THIRD RESTATEMENT"). ERISA's goals support the result dictated by trust law. The statutory goal that dominated the Court's opinion in *Firestone* was "to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." 489 U.S. at 113 (citations 14 and internal quotation marks omitted). As in *Firestone*, this concern supports careful scrutiny. *Firestone* held that the default rule in an ERISA case is *de novo*, because otherwise employees would have less protection than they had pre-ERISA. The same is true here. If a court must give a dual-role insurer utmost deference, without any consideration of the conflict, an employee who was the victim of an improperly motivated benefit denial would be much worse off than he would have been with a contract claim under ERISA. As is evident from the Restatements, treaties and trust cases quoted above, a dual role conflict is an actual conflict, because "the administrator has an interest (e.g., in profit or a better bottom line) that is adverse to the interests of the beneficiaries seeking payment." *Post v. Hartford Ins. Co.*, 501 F.3d 154, 163 (3rd Cir. 2007). Regardless of what the employer might consent to, the statue requires a fiduciary always to "discharge his duties with respect to a Plan solely in the interest of the beneficiaries for the exclusive purpose of providing benefits to the participants and their beneficiaries." 29 U.S.C. § 1104(a)(1)(A)(i). The Plan worries that diminished deference leads to higher

costs and more frivolous litigation. This Court considered and rejected those arguments when it chose *de novo* review as ERISA's default standard. The arguments are even less compelling in a dispute over standards for a conflicted fiduciary. In any event, the rule The Plan opposes has been in place for decades in most courts, and no such dire consequences have materialized. Equally meritless are The Plan's various other arguments against weighing the conflict. None of the supposed business realities apply. Similarly, arbitrary – and capricious review will not suffice to guard against an insurer's conscious or subconscious shading of benefit decisions. And state and federal administrative agencies do not, and are not expected to protect individual claimants. Congress prescribed complementary roles for *both* regulators and judges. While regulators provide *systematic* oversight, Congress gave judges the responsibility to review individual claims for benefits due – like this one – under § 1132(a)(1)(B), and to do so in a way that advances both ERISA's goal of protecting claimants' contract rights and its unswayable requirement that Plan fiduciaries act in the sole interest of beneficiaries. *Glenn v. Metropolitan Life Ins. Co.*, Supreme Ct. ruling #06-923, June 19, 2008. Furthermore in ERISA cases, most courts of appeals, echoing trust law, have held that a conflicted fiduciary's judgment will be scrutinized more closely, which means that "deference will be lessened." *Doe v. Group Hospitalization & Med. Services*, 3 F.3d 80, 86-87 (4th Cir. 1993). *Brigham v. Sun Life of Can.*, 317 F.3d 72, 81-86 (1st Cir. 2003). The lower courts need this Court's guidance

not just on the name of the standard but on how to apply it. "Reasonableness", in trust law, requires more than just some rational connection between a shred of evidence and the conclusion. *Copp v. Worcester County National Bank*, 199 N.E.2d 200, 202 (Mass. 1964).

A. Deference to a Dual-Role Insurer Should Decline As Scrutiny Exposes Additional Reasons That the Conflict May Have Affected the Insurer's Decision

At some point the suspicion of taint can be sufficiently strong that the reviewing court should give no deference to the conflicted insurer's decisions and apply *de novo* review. The presence of these factors would have justified diminishing deference far below the level of "careful scrutiny" and even all the way to zero . . . *de novo* review. In Mehen's case the Plan's interpretation "defied all common sense." *Dabertin v. HCR Manor Care, Inc.*, 373 F.3d 822, 828 (7th Cir. 2004). See Kathryn Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U.L. REV. 1083, 1155 (2001); *Stup v. Unum Life Ins. Co. of Am.*, 390 F.3d 301, 307 (4th Cir. 2004) (quoting *Ellis*, 126 F.3d at 233); *Wright v. Donnelly & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74 (1st Cir. 2005); *Van Boxel v. Journal Co. Employee's Pension Trust*, 836 F.2d 1048, 1052-53 (7th Cir. 1987); *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d at 789, 794, 797, 799-780 (9th

Cir. 1997). Under trust law the only reason a fiduciary enjoys any deference is that he is obligated to make decisions wholly in the interests of the beneficiary. See *Clement v. Larkey*, 863 S.W.2d 580, 581-82 (Ark. 1993); *Buchar's Estate*, 74 at 237. In determining whether to diminish deference, courts should be free to evaluate any evidence bearing on the conflict or the fiduciary's behavior. *Fought v. Unum Life Ins. Co. of America*, 379 F.3d 997 (10th Cir. 2004). The most common form of evidence that a conflicted fiduciary succumbed to the conflict is evidence about the process. . . . "how the administrator treated the particular claimant." This category includes various "irregularities" such as: "(1) reversal of position without additional medical evidence; (2) self-serving selectivity in the use and interpretation of physicians' reports; (3) disregarding staff recommendations that benefits be awarded," (4) "providing inconsistent reasons for denial"; (5) "failing adequately to investigate a claim"; (6) "failing to credit a claimant's reliable evidence," *Abatie*, 458 F.3d at 968; and (7) denying disability after advocating disability to the Social Security Administration, without explaining the difference, *Ladd v. ITT Corp.*, 148 F.3d 753, 755-56 (7th Cir. 1998). Mehen's case included most of the above statutory violations, irregularities and lack of compliance which provided ample evidence of a conflict of interest, any of these factors would have justified diminished deference far below the level of "careful scrutiny" . . . even all the way to zero, to *de novo* review. The lower courts failed to consider this ample evidence of a conflict of interest. Additionally,

other factors the courts of appeals have identified in this category are: (1) whether the administrator "uses an independent body to evaluate claims"; (2) "whether the insurance contract is fixed for a term of years or changes annually; (3) whether the fee paid by the company is modified if there are especially large outlays of capital by the insurer"; (4) whether the insurer has displayed "a parsimonious claims-granting history," *Abatie*, 458 F.3d at 968-69, *Unum Group Swings to Profit from Quarterly Loss*; *Claims Reassessment 'Substantially Completed'*, BEST WIRE (Nov. 1, 2006). The Ninth Circuit "sliding scale" approach was not used in my case, *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998).

B. As This Court Has Held A Claim Administrator Must Specifically Consider A Bare Determination Of The Social Security Administration Which Must Be Considered By An ERISA Administrator

The Plan never disagreed with the SSA determination, after requiring Mehen to apply for SSA benefits. That about-face action alone can be considered "arbitrary and capricious".

The Plan also failed to give any weight to Dr. Gray's reports, in which he clearly stated Mehen's total disability and stated "not eligible to engage in any gainful employment", made mischaracterizations of the medical report, ignoring medical evidence . . . "by itself, is arbitrary and capricious." Peter J. Wiedenbeck,

ERISA in the Courts 194 (2008). Savvy insurers will "cherry pick" and accentuate their best facts, while ignoring their worst facts with little explanation. *Schatz v. Mutual of Omaha Ins. Co.*, 220 F.3d 944 (8th Cir. 2000).

C. The New Case Law Standard Should Be Applied Invoking a *de novo* Standard Of Review Which Will Require An Alternate Conclusion

I respectfully ask the Court to apply the new case law standard to reiterate the decision and affirm that a conflict of interest must be weighed as a factor in this matter of *Mehen v. Delta Airlines, Inc., et al.*, as you found in *Glenn v. MetLife Ins. Co.*, 06-923 Super Ct. June 19, 2008.

In addition, the Respondent's Bankruptcy Court case has tried to wrongfully include ERISA issues which are not a part of the Debtor's estate further trying to escape responsibility and complicate these issues, I cite *Patterson v. Shumate*, No. 91-9131992, nor should any penalties paid by the Plan be a part of the Bankruptcy Court, as the Plan is not a part of the Debtor/Respondent's estate. The denial of benefits, mischaracterization of the medical records, lack of compliance, false surveillance DVD, failing to provide the false surveillance DVD, the many statutory violations and harassment campaign were done with malicious intent and must be penalized sending a clear message, that these actions will not be tolerated. The

$110.00 penalty must be levied against the respondents, levied and enforced to the maximum extent that the law allows. 29 U.S.C. § 1024(6)(4), Sec. 502(c)(a)(1)(A), *Castello v. Gamache*, 593, 361 (8th Cir. 1979), H.R. 1592 Mathew Shepard Act 2007, and all protections provided by the Americans with Disabilities Act. Also, 29 C.F.R. § 1604.01(e) states "that the employer can be held liable for harassment, if the employer knew of the harassment and failed to stop harassment", the eye witness accounts on the night of June 13, 2003 when the man delivering papers by day (for Respondent's local attorneys) was identified at night harassing our family at our house, it directly links the ongoing harassment to the respondents, Delta Airlines, Inc., et al. Also, in *Glenn v. Met. Life Ins. Co.*, 2007 U.S. Dist. Lexis 1421, at *12 (S.D. Ohio Jan. 8, 2007), the District Court found MetLife's "culpability . . . high" and ordered MetLife to pay Ms. Glenn's attorney's fees and costs.

CONCLUSION

I pray that the Court will grant the Writ of Certiorari to resolve the questions above. For these reasons, the judgment of the Court of Appeals should be vacated or reversed.

Respectfully submitted,

DANA LYNN MEHEN
Pro Se
2968 N. Webster Rd.
Tucson, Arizona 85750
(520) 290-9067

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DANA LYNN MEHEN, Plaintiff-Appellant, v. DELTA AIRLINES, INC.; DELTA FAMILY CARE MEDICAL PLAN; DELTA FAMILY CARE DISABILITY AND SURVIVORSHIP PLAN; ADMINISTRATIVE SUBCOMMITTEE; ADMINISTRATIVE COMMITTEE; LEO MULLINS; SHARON WIBBEN, Vice President of In-Flight; UNITED HEALTHCARE, for the Medical Plan-Sponsored by Delta Airlines; COBRA ADMINISTRATORS, ERISA BENEFITS; LEON PIPER, Vice President of Worldwide Benefits; CHRISTOPHER YOUNG, Long Term Disability Administrator; ANNETTE FRAZIER, Long Term Disability Administrator; BEVERLY HORD, Long Term Disability Secretary; ROBERT HEILMANN, COBRA	No. 06-16388 D.C. No. CV-02-00595-CKJ MEMORANDUM* (Filed Oct. 24, 2008)

* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

Department Supervisor; BRIAN KING, Administrative Secretary; JAMES O'BRIEN; DDI COMPANY; PAT HIGGINS,

Defendants-Appellees.

Appeal from the United States District Court
for the District of Arizona
Cindy K. Jorgenson, District Judge, Presiding

Submitted June 6, 2008**

Before: SKOPIL, FARRIS, and BEEZER, Circuit Judges.

Dana Mehen brought this ERISA action against her former employer and its long-term disability plans, challenging the termination of her disability benefits. She argues the district court erred by reviewing the termination decisions for an abuse of discretion rather than applying de novo review. We conclude the court applied the proper standard and accordingly we affirm.

The proper standard of review depends on the language of the plan. If the plan administrator is not empowered by the plan "to determine eligibility for benefits or to construe the terms of the plan," the court's review is de novo. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). "But if the plan

** The panel unanimously finds this case suitable for decision without oral argument. *See* Fed. R.App. P. 34(a)(2).

does confer discretionary authority as a matter of contractual agreement, then the standard of review shifts to abuse of discretion." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 963 (9th Cir. 2006) (en banc) (italics in original).

The plan here provides for "the broadest discretionary authority permitted under law in the exercise of all of its functions, including, but not limited to, deciding questions of eligibility and interpretation." Such language clearly confers discretion on the plan administrator to make final benefit determinations. *See id.* (noting "similar plan wording – granting the power to interpret plan terms and to make final benefits determinations – confers discretion on the plan administrator").

Mehen nonetheless argues the plan administrator has an inherent conflict of interest in protecting profits and thus de novo review is appropriate. We have held, however, that the "[a]buse of discretion review applies to a discretion-granting plan even if the administrator has a conflict of interest." *Id.* at 965. Mehen also argues for de novo review based on her claims of "procedural violations." Even assuming there were such violations, "a procedural irregularity in processing an ERISA claim does not usually justify de novo review." *Id.* at 972. Rather, "[a] procedural irregularity, like a conflict of interest, is a matter to be weighed in deciding whether an administrator's decision was an abuse of discretion." *Id.*

Under an abuse of discretion standard, the plan administrator's decision may be set aside "only when it is arbitrary and capricious." *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan,* 370 F.3d 869, 875 (9th Cir. 2004). A decision is not arbitrary or capricious if "grounded on *any* reasonable basis." *Id.* (italics in original). Thus, "as long as the record demonstrates that there is a reasonable basis for concluding that the medical condition was not disabling, the decision cannot be characterized as arbitrary, and we must defer to the decision of the plan administrator." *Id.* at 879. Although there was conflicting medical evidence regarding Mehen's level of disability, we agree with the district court that the plan administrator's decision to terminate Mehen's disability benefits cannot be said to be arbitrary and capricious or an abuse of discretion.

There was also no abuse of discretion when the plan denied Mehen's request for an extension of her COBRA benefits. Mehen's "qualifying event" did not occur within the initial 18-month COBRA period and she did not notify the plan administrator within 60 days of the date of the event as required by the plan.

AFFIRMED.

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

Dana Lynn Mehen, Plaintiff, vs. Delta Airlines, Inc., et al., Defendants.	)	No. CV 02-00595 TUC CKJ **FINAL JUDGMENT**

WHEREAS, having considered the parties' written memoranda, evidence submitted, oral arguments and the applicable law:

(a) The Court granted by Order filed May 11, 2005, the Motion for Summary Judgment of the Administrative Committee of Delta Air Lines, Inc., the Administrative Subcommittee of Delta Air Lines, Inc., the Delta Family-Care Disability and Survivorship Plan and the Delta Family-Care Medical Plan (the "ERISA Defendants") on all claims brought against them by plaintiff;

(b) The Court, in the same Order, granted the Motion for Summary Judgment of Delta Air Lines, Inc. on all claims brought against it by plaintiff; and

(c) The Court, by Order dated May 12, 2006, dismissed with prejudice the ERISA Defendants counterclaim against plaintiff with prejudice,

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED:

1. That Delta's Motion for Summary Judgment be granted as to each and every claim brought against Delta by plaintiff, and that final judgment be entered herein in favor of Delta on plaintiff's claims;

2. That the ERISA Defendants' Motion for Summary Judgment be granted as to each and every claim brought against the ERISA Defendants by plaintiff, and that final judgment be entered herein in favor of the ERISA Defendants;

3. That judgment be entered in favor of Plaintiff and against the ERISA Defendants on the counter-claim brought by the ERISA Defendants against plaintiff; and

4. That the parties recover nothing from any of the other parties.

Dated this 15th day of June, 2006.

/s/ Cindy K. Jorgenson
Cindy K. Jorgenson
United States District Judge

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

Dana Lynn Mehen, Plaintiff, vs. Delta Airlines, Inc., et al., Defendants.	)	**JUDGMENT IN A CIVIL CASE** Case No. CV 02-00595 TUC CKJ (Filed May 18, 2006)

DECISION BY COURT. This action came under consideration before the Court. The issues have been considered and a decision has been rendered.

IT IS HEREBY ORDERED AND ADJUDGED that the ERISA Defendants' counterclaim is **DISMISSED WITH PREJUDICE.**

May 12, 2006
Date

RICHARD H. WEARE
CLERK

/s/ Jill Tarlton
By: Jill Tarlton
Deputy Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Dana Lynn Mehen, Plaintiff, vs. Delta Airlines, Inc., et al., Defendants.	No. CV 02-00595-TUC-CKJ **ORDER** (Filed May 11, 2006)

Pending before the Court is the ERISA Defendants' request to voluntarily dismiss the case (Doc. #202). As summary judgment has already been granted as to all of Plaintiff's claims, the ERISA Defendants' counterclaim is the only remaining claim in this case. As such, pursuant to FED.R.CIV.P. 41(a)(2), IT IS HEREBY ORDERED that the ERISA Defendants' counterclaim is **dismissed with prejudice**. IT IS FURTHER ORDERED that the **Clerk of the Court shall dismiss this case with prejudice, close the file in this matter, and enter judgment accordingly**. In light of this dismissal, the status conference scheduled for 5/12/06 is vacated.

DATED this 11th day of May, 2006.

/s/ Cindy K. Jorgenson
Cindy K. Jorgenson
United States District Judge

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DANA LYNN MEHEN, Plaintiff-Appellant, v. DELTA AIRLINES, INC.; et al., Defendants-Appellees,	No. 06-16388 D.C. No. CV-02-00595-CKJ District of Arizona, Tucson ORDER (Filed Dec. 11, 2008)

Before: SKOPIL, FARRIS, and BEEZER, Circuit Judges.

We construe Mehen's pro se request for rehearing to be both a petition for panel rehearing and a petition for rehearing en banc. The panel has voted unanimously to deny the petition for rehearing. The full court has been advised of the petition for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. *See* Fed. R. App. P. 35. Accordingly, the petition for rehearing is DENIED and the petition for rehearing en banc is DENIED.

(2)

No. _____

Supreme Court, U.S.
FILED

081533 MAR 9 - 2009

OFFICE OF THE CLERK
William K. Suter, Clerk

In The

Supreme Court of the United States

DANA LYNN MEHEN,

Petitioner,

vs.

DELTA AIRLINES, INC., et al.,

Respondents.

On Petition For A Writ Of Certiorari To The Ninth Circuit Court Of Appeals

SUPPLEMENTAL APPENDIX

DANA LYNN MEHEN
Pro Se
2968 N. Webster Rd.
Tucson, Arizona 85750
(520) 290-9067

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Dana Lynn Mehen, Plaintiff, vs. Delta airlines, Inc., et al., Defendants.	)	No. CV 02-595-TUC-CKJ **ORDER** (Filed May 11, 2005)

Pending before the Court is Delta Airlines Inc.'s ("Delta") Motion for Summary Judgment and the Motion for Summary Judgment of the Administrative Committee of Delta Airlines, Inc.; the Administrative Subcommittee of Delta Airlines, Inc.; the Delta Family-Care Disability and Survivorship Plan and the Delta Family-Care Medical Plan (hereinafter, the "ERISA Defendants"). For the reasons stated below, Delta's Motion for Summary Judgment and the ERISA Defendants' Motion for Summary Judgment seeking to dismiss Plaintiff's claims are granted; however, the ERISA Defendants' Motion for Summary Judgment on the counterclaim is denied.

I. STANDARD OF REVIEW ON A MOTION FOR SUMMARY JUDGMENT

Summary judgment is appropriate where "there is no genuine issue as to any material fact." Fed. R. Civ. P. 56(c). A genuine issue exists if "the evidence is such that a reasonable jury could return a verdict for

the nonmoving party," and material facts are those "that might affect the outcome of the suit under the governing law." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). A fact is "material" if, under the applicable substantive law, it is "essential to the proper disposition of the claim." *Id.* An issue of fact is "genuine" if "there is sufficient evidence on each side so that a rational trier of fact could resolve the issue either way." *Id.* Thus, the "mere scintilla of evidence" in support of the nonmoving party's claim is insufficient to defeat summary judgment. *Id.* at 252. However, in evaluating a motion for summary judgment, "the evidence of the nonmoving party is to be believed, and all justifiable inferences are to be drawn in his favor." *Id.* at 255.

II. FACTUAL BACKGROUND

As a threshold matter, the Court notes that Plaintiff's exhibits in opposition to the motions for summary judgment were not attached to Plaintiff's statement of facts, the exhibits are not bound together in one stack, and there are no exhibit tags protruding from the exhibits allowing easy identification. Further, Plaintiff only filed copies of these exhibits with the Clerk's Office, but failed to file copies of these exhibits with the Court in violation of Local Civil Rule 5.4. Rather, Plaintiff submitted a stack of documents in eight separate manilla envelopes. The Court also notes that Plaintiff submitted approximately 45 exhibits, and that the Plaintiff's Statement of Facts cites to less than half of those exhibits.

Further, to the extent Plaintiff may cite to exhibits in her Statement of Facts or in her briefs, she often fails to specifically discuss and specifically cite the relevant portions. Further, the Court notes that although it has reviewed and considered Plaintiff's exhibits, it is not required to comb through Plaintiff's exhibits in search of a reason to deny Defendants' Motion for Summary Judgment. *See Carmen v. San Francisco Unified School District,* 237 F.3d 1026, 1029-1031 (9th Cir. 2001). To require otherwise would render this Court the lawyer for the Plaintiff, performing the lawyer's duty of setting forth specific facts creating a genuine issue sufficient to defeat the motion. *See id.* Second, only *material* facts are relevant for the purposes of motions for summary judgment. *See* Fed. R. Civ. P. 56(c); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Submitting a stack of documents (which often have not been specifically discussed and specifically cited for support) in opposition to a motion for summary judgment have limited value and do not help the Court in determining the key issues. Lastly, besides citing one invalid case that was overturned, the Court notes that Plaintiff fails to cite to any specific authority in her briefs opposing the motions for summary judgment.

A. Long Term Disability

The claims in this case primarily arise out of the ERISA Defendants' decisions denying Plaintiff continued long term disability benefits and COBRA benefits.

Plaintiff began working for Delta as a flight attendant 1977. Since 1994, she has not performed any work for Delta due to various medical conditions which allegedly prevent her from performing any work whatsoever. Plaintiff began receiving short term disability benefits in 1994, and began receiving long-term disability ("LTD") benefits in February of 1995 through the Delta Family-Care Disability & Survivorship Plan ("LTD Plan"). Plaintiff continued to receive benefits under the LTD until September 1, 2000; benefits were discontinued as it was determined that Plaintiff was no longer disabled by the Administrative Committee which is the Plan Administrator and Fiduciary for the LTD Plan. Plaintiff now challenges the final decision of the Administrative Committee affirming the denial of LTD benefits based on the finding that she was no longer disabled as defined by the LTD Plan.

The LTD Plan is an employee benefit plan established and maintained pursuant to ERISA. Section 4.03 relating to qualifications for LTD benefits states:

> The Employee shall be eligible for Long Term Disability provided he is disabled at that time as a result of demonstrable injury of disease (including mental or nervous disorders) which will **continuously and totally prevent him from engaging in any occupation whatsoever for compensation or profit, including part-time work**. (emphasis added).

Further, §12.02 states that the Administrative Committee shall decide all issues under the LTD Plan and that:

> The Administrative Committee **shall have the broadest discretionary authority permitted under law** in the exercise of all of its functions, including, but not limited to, deciding questions of eligibility and interpretation . . . (emphasis added).

Where LTD benefits are denied, a claimant may appeal to the Administrative Subcommittee, and if necessary, may appeal to the Administrative Committee which is the final authority on the administrative appeal.

To remain qualified for LTD benefits, Plaintiff had to show that she continued to meet the LTD Plan's definition of disability. On March 2, 1999, Plaintiff's psychiatrist/occupation medicine specialist, Dr. Gray, stated that Plaintiff was permanently disabled due to fatigue, weakness, and cognitive functions. Subsequently, the LTD Plan asked Plaintiff to attend an independent medical exam ("IME") on June 22, 1999 with Dr. Alkasspooles, an infectious diseases specialist. Dr. Alkasspooles determined that "[u]pon reviewing her physical exam, besides some decrease in strength and maybe decrease in gait, I do not see any other physical limiting factors in this patient." *See* ERISA Defendants' Exhibit B at Meh/LTD 258. As such, Dr. Alkasspooles found that Plaintiff had no physical limitations to performing part-time sedentary work, and the only restriction was lifting heavy

weights. While Dr. Alkasspooles stated that he thought Plaintiff was still disabled, this was based largely on psychological limitations he perceived which were outside his expertise. As such, he recommended that Plaintiff receive psychotherapy with a psychiatrist. The LTD Plan then asked Plaintiff to attend an IME with Dr. O'Brien, a psychiatrist. Dr. O'Brien stated in relevant part:

> [Claimant] has a firm, militant disability conviction. However, there are very few objective findings to support this degree of claimed disability. Basically, Ms. Mehen is unable to work because she feels she is unable to work. There are plenty of people in the workplace who have [a] history of gallbladder problems, thyroid problems, mild depression, mild rheumatologic problems, etc., but they are able to work in some capacity. I have no idea why her doctors have recommended her taking off this much time. In fact, if anything, I think this has been injurious to her condition. This has led to inculcation of learned helplessness and other maladaptive psychological mechanisms. I have seen nowhere in her entire history of illness that she has appeared motivated to work. It is not surprising that she has not shown much improvement since being off work.
>
> It is my opinion that Ms. Mehen is capable of performing her duties as a flight attendant or alternative job occupation. . . . I see no reason, why, on a psychiatric basis, she is

> unable to work. The fact that she is angry and bitter about the system and her preoccupation with somatic symptoms is not a psychiatric preclusion to gainful employment.
>
> I do not believe there are disabling factors. What we are essentially dealing with here is a bad attitude rather than real objective psychopathology.

See ERISA Defendants' Exhibit B at Meh/LTD 267-268. Dr. O'Brien's report was subsequently forwarded to Dr. Alkasspooles. Based on this psychiatric opinion and his prior analysis, he ultimately concluded that Plaintiff could resume working. Based on this evidence, the LTD Plan concluded that Plaintiff no longer met the definition of disabled in the plan and discontinued benefits effective September 1, 2000.

Plaintiff thereafter appealed to the Administrative Subcommittee on October 13, 2000. As part of the appeal, she submitted additional documentation from Dr. Gray, Dr. Brautbar, Dr. Baumzweiger, and Dr. Karam. Dr. Gray continued to conclude that Plaintiff was totally disabled due to various exposures to toxic substances, and that she suffered various disabling ailments including chronic fatigue syndrome. Dr. Brautbar concluded, without explanation, that Plaintiff was totally disabled. Dr. Baumzweiger concluded that Plaintiff was totally disabled and that she was suffering from neurotoxicity. Lastly, a polysonogram was submitted from Dr. Kram, but Dr. Kram offered no opinion as to whether Plaintiff could work.

As part of the appeal, the Administrative Subcommittee scheduled Plaintiff for an IME with Dr. Stoney, a physical medicine and rehabilitation specialist. He concluded that from a "physical standpoint, this patient is able to resume work duty at this time. She can functionally at this time tolerate sitting, standing, walking, clerical duties of filing, and data entry." *See* ERISA Defendants' Exhibit B at Meh/LTD 400. From a psychiatric standpoint, he deferred to Dr. O'Brien as that was his specialty. As such, Dr. Stoney concluded that Plaintiff could begin working performing clerical duties. On April 12, 2001, based on all of the evidence before it, the Administrative Sub-Committee affirmed the prior determination that benefits were correctly denied as Plaintiff was capable of performing some type of work. Plaintiff thereafter took her final administrative appeal to the Administrative Committee. Plaintiff submitted additional reports from Dr. Gray, Dr. Brautbar, and Dr. Baumzweiger who all continued to conclude that Plaintiff was totally disabled. Plaintiff also submitted a report from Dr. Frank, specializing in psychiatry and neurology, who described her overall disability as between slight (20%) to moderate (50%). Dr. Frank's report was originally produced in relation to Plaintiff's separate workers' compensation claim. The Administrative Committee forwarded these materials to Dr. Stoney for his review. These materials did not change Dr. Stoney's opinion that Plaintiff was no longer disabled. Based on the opinions of Dr. Alkasspooles, Dr. O'Brien, and Dr. Stoney, the Administrative Committee found that Plaintiff could resume working in some

capacity, and that she was no longer disabled as defined by the LTD Plan. The Administrative Committee further noted that Dr. Gray's conclusions were largely unsupported by objective findings, that Dr. Brautbar's and Dr. Baumzweiger's statements focused on California workers' compensation requirements, and that Dr. Frank's report actually supported the Administrative Committee's conclusion as Dr. Frank reported that Plaintiff was only slightly to moderately disabled. Accordingly, based on the evidence before it, the Administrative Committee affirmed the denial of Plaintiff's LTD benefits.

B. COBRA/Continuation Coverage

Once Plaintiff initially lost her LTD benefits effective September 1, 2000, she was no longer entitled to continue coverage under the Delta Family-Care Medical Plain ("Medical Plan"). As such, Plaintiff was notified of this situation and informed of her right to temporarily continue coverage under COBRA as of September of 2000. Plaintiff elected to continue coverage, and received COBRA benefits for the standard 18 month period which ended on February 28, 2002. She requested an extension of these benefits beyond the 18 months, which were denied and this denial was affirmed on final administrative appeal by the Administrative Subcommittee. Plaintiff challenges this decision.

The Medical Plan is also an employee benefit plan pursuant to ERISA, and the Administrative

Committee is also the Plan Administrator. Where an employee disagrees with a denial of benefits, the employee is permitted an appeal (which is the final appeal) to the Administrative Subcommittee. The Administrative Subcommittee has the broadest discretion permitted by law in deciding such an appeal in relation to the denial of continued benefits under the Medical Plan. *See* ERISA Defendants' Exhibit C at MP 105 and MP 112.

Section 9.07 of the Medical Plan limits extensions of COBRA benefits beyond the standard 18 months. It states that "[c]ontinuation coverage shall extend for a period of 18 months after the date that regular coverage ceased . . . unless during such 18-month period a subsequent Qualifying Event occurs." *Id.* at MP 97. Regular coverage for Plaintiff ceased on September 1, 2000. Her original 18 month continuation/COBRA coverage began on September 1, 2000 and ended on February 28, 2002. Plaintiff requested to continue coverage because of the alleged subsequent qualifying event that she was determined to be disabled by the Social Security Administration. Section 9.07 provides that an extension beyond the standard 18 month continuation period under COBRA may be authorized only when the person seeking the extension provides notice of the Social Security determination of disability coverage "within (60) days after the date of such determination and before the end of the initial 18-month continuation coverage period." *Id.* at MP 97. The request to continue coverage was originally denied because she was told that her disability did

not start within the first 60 days of her COBRA coverage. On final appeal, the Administrative Subcommittee affirmed the decision on a different ground. It stated that it "is not mandatory that your disability actually start within the first 60 days of COBRA, coverage; however, you must be determined to be disabled by Social Security at any time during the first 60 days of coverage." *Id.* at Meh/Cobra 7. Here, Plaintiff was determined to be disabled by the Social Security Administration on December 30, 1995, effective as of June 26, 1994. Plaintiff was determined to be disabled by the Social Security Administration approximately 6 years prior to the start of her continuation/COBRA coverage on September 1, 2000. As such, the Administrative Subcommittee determined that this event did not occur subsequent to her continuation/COBRA coverage which started on September 1, 2000, and she obviously was not determined to be disabled by Social Security during the first 60 days of COBRA coverage. As such, the Administrative Subcommittee found that the denial of COBRA benefits beyond the original 18 month period was proper.

C. Disability Harassment

Throughout Plaintiff's "Statement of Fact," the entire set of facts essentially focuses on the denial of LTD and COBRA benefits. The only specific reference to disability discrimination is based on Plaintiff's claim of Delta's harassment of her based on her disability in paragraph 26. Paragraph 26 states:

> Mehen has been harassed since her disclosure to Delta Airlines INC. in 1997 that she was a disabled individual. (Exhibits 41, 42, 43, 44, 45). There have been vehicles parked at the entrance to Mehen's, they have been seen driving by Mehen's residence at all hours of the day and night and vehicles have attempted to crash Mehen's front gate. There have also been anonymous phone calls originating in Atlanta, Georgia the headquarters for Delta Airlines INC. and the ERISA defendants, other calls asking question about Mehen."

However, as discussed below, the exhibits cited by Plaintiff do not show that Delta was in any way involved with these actions.

III. DISCUSSION

A. Denial of LTD Benefits, Denial of COBRA Benefits, and Fiduciary Duty

The ERISA Defendants correctly argue that the denial of benefits at issue are governed by the Employee Retirement Income Security Act ("ERISA"). *See* 29 U.S.C. §1001 et seq., 29 U.S.C. §1002(1). As already discussed above, the controlling documents for the plans give the ERISA Defendants the broadest discretionary authority permitted by law. Where such discretion is given, the Ninth Circuit holds that the standard of review is as follows:

> [w]here discretion is conferred upon the [Plan Administrator] with respect to the

> exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion . . . When we review for abuse of discretion, it is because the plan has put the locus for decision in the plan administrator, not in the courts, so we cannot substitute our judgment for the administrator's. We can set aside the administrator's discretionary determination only when it is arbitrary and capricious. We have held that a decision grounded on *any* reasonable basis is not arbitrary or capricious, and that in order to be subject to reversal, an administrator's factual findings that a claimant is not totally disabled must be clearly erroneous.

Jordan v. Northrop Grumman Corp. Welfare Benefit Plan, 370 F.3d 869, 875 (9th Cir 2004) (internal quotes and citations omitted).[1] Further, review is limited to the administrative record before the Plan Administrator at the time of the decision in question

---

[1] In arguing that there is a less deferential standard of review due to a conflict of interest, the ERISA Defendants correctly argue that Plaintiff relies on an overturned decision in *Regula v. Delta Family-Care Disability and Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), *vacated* 539 U.S. 901 (2003), *judgment* for Plan *affirmed* 354 F.3d 1133 (9th Cir. 2004) (affirming District Court's decision in favor of the Plan based on arbitrary and capricious standard). As such, Plaintiff's argument is without merit. *See also Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 370 F.3d at 876 (fact that plan would not have to pay benefits if claim was denied does not create a conflict of interest).

was made. *See id.* at 879. As the Ninth Circuit and Supreme Court have emphasized, disability determinations under ERISA plans are made pursuant to the provisions of the plan itself, as opposed to the criteria set out in Social Security cases for disability. *See id.* at 878-879. Such a determination is distinct from a Social Security disability determination and not governed by rules pertaining to Social Security cases. *See id.* Thus, "a treating physician's opinion gets no special weight and can be rejected on the basis of reliable evidence with no discrete burden of explanation . . . [thus courts are prohibited] from overturning discretionary decisions by administrators because they failed to defer to treating physicians' opinions." *See id.* (citing *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003)). Further, the fact that there is conflicting evidence as to whether a claimant can work does not make the denial of benefits arbitrary or capricious. As the Ninth Circuit found in *Jordan*:

> The administrator here had conflicting reports from [Claimant's] treating physicians and [the Plan's] reviewing physicians. This is typical of the evidence used in disability determinations. Reasonable people can disagree on whether [Claimant] was 'disabled' for purposes of the ERISA plan. Because that is so, the administrator cannot be characterized as acting arbitrarily in taking the view that she was not.

See id. at 880.

Here, the administrative record supports the denial of LTD benefits. The Administrative Committee's decision is supported by the opinions of several different doctors who personally examined Plaintiff. After reviewing Plaintiff's physical exam, Dr. Alkasspooles, a specialist in infectious diseases, determined that Plaintiff had no physical limitations besides some decrease in strength and maybe some decrease in gait. Thus, he determined that Plaintiff was not physically prevented from performing some work. As to her potential mental issues, Dr. Alkasspooles deferred to a professional psychiatric opinion as this was not his specialty. Dr. O'Brien, a psychiatrist, determined that there was no reason on a psychiatric basis why Plaintiff could not resume working. Dr. Stoney, a physical medicine and rehabilitation specialist, also determined that Plaintiff was physically able to resume work. Further, a report submitted by Plaintiff from Dr. Frank also found that Plaintiff was only slightly to moderately disabled. Lastly, the Administrative Committee also noted that opinions from the doctors submitted by Plaintiff were largely unsupported by objective findings and were based on criteria distinct from the definition of disability contained in the LTD Plan. Although there were conflicting opinions as to Plaintiff's disability, the Court can not say that the Administrative Committee's decision to affirm the denial of LTD benefits was arbitrary and capricious as the decision is supported by sufficient evidence from the administrative record. Thus, summary judgment is granted in favor of the ERISA Defendants on this issue.

The denial of the continuation of COBRA benefits was also supported by the record. The Medical Plan limits extensions of COBRA benefits beyond the standard 18 month period. As discussed above, it states that "[c]ontinuation coverage shall extend for a period of 18 months after the date that regular coverage ceased . . . unless during such 18-month period a subsequent Qualifying Event occurs." Regular coverage for Plaintiff ceased on September 1, 2000. Her original 18 month continuation/COBRA coverage began on September 1, 2000 and ended on February 28, 2002. Plaintiff requested to continue coverage based on the fact that she was determined to be disabled by the Social Security Administration. The Medical Plan further provides that an extension beyond the original 18 month continuation period is permissible only if the person seeking the extension provides notice of the Social Security determination of disability coverage "within (60) days after the date of such determination and before the end of the initial 18-month continuation coverage period." Plaintiff was determined to be disabled by the Social Security Administration on December 30, 1995, effective as of June 26, 1994. As such, the Administrative Subcommittee properly determined that this event did not occur subsequent to her continuation/COBRA coverage which started on September 1, 2000, and properly found that she was not determined to be disabled by Social Security during the first 60 days of COBRA coverage as required to continue COBRA benefits beyond 18 months. As such, the Court finds that the decision of the Administrative Subcommittee was not

arbitrary and capricious. Summary judgment is granted in favor of the ERISA Defendants on this issue. Lastly, Plaintiff claims that the ERISA Defendants breached their fiduciary duties by improperly denying LTD and COBRA benefits. However, the Court has already found that benefits were properly denied. As such, summary judgment is granted in favor of the ERISA Defendants on Plaintiff's claim for breach of fiduciary duty for the same reasons stated above in relation to the denial of benefits.

Further, as Delta correctly argues, Plaintiff has no viable claim against Delta for the denial of benefits or for breach of fiduciary duty as the ERISA Defendants, not Delta, was responsible for the denial of benefits. Delta is neither the Plan Administrator or Named Fiduciary. Delta is a separate legal entity from the ERISA Defendants, and as such, can not be held responsible for the ERISA Defendant's denial of benefits under ERISA. *See Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324-25 (9th Cir. 1985) (per curium); 29 U.S.C. §1132(d)(1) & (2); *Zelder v. Delta Air Lines, Inc.*, 423 So. 2d 945, 946 (Fla Ct. App. 1983). Plaintiff has not provided any authority refuting this conclusion. Accordingly, to the extent Plaintiff is asserting claims against Delta for the denial of benefits or breach of fiduciary duty, summary judgment is granted in favor of Delta.

B. Disability Discrimination

1. Disability Discrimination Based on Termination

Plaintiff first claims that she was terminated based on her disability. However, Delta argues that she was never terminated. *See* Delta's Exhibit B (Affidavit of the Director of Equal Opportunity for Delta stating that Delta never terminated Plaintiff, but had her on the roles as an inactive flight attendant since her claims of disability arose in 1994). Rather, Defendant argues that the evidence Plaintiff relies on for her opinion that she was terminated does not support the conclusion that she was actually terminated by Delta. The Court agrees.

Plaintiff relies on a March 6, 2002 letter from the administrator of the COBRA plan which has the phrase not in "current employment," which she interpreted to mean that she was terminated. However, the letter which denied her request for extended COBRA coverage also addressed the coordination of her COBRA benefits with her Medicare benefits. *See* Delta's Exhibit 2. The letter informed her that Medicare now provided her primary health coverage because she was not in "current employment," which is defined under Medicare regulations. *See id.*; *see also* 42 C.F.R. §§411.104 & 411.20. This letter was also sent from the COBRA plan administrator, who is a separate legal entity from Delta. This letter does not show that she was terminated. Plaintiff also relies on a June 12, 2002 letter from Delta requesting the return of her

identification badge. *See* Delta Exhibit 2. However, this was a form letter sent to employees who were not only terminated, but was also sent to employees who were on inactive status due to an extended leave. This letter does not show that she was terminated.

Plaintiff also relies on inadmissible hearsay to claim that she was terminated. In her deposition, she said that an EEOC investigator stated "something had happened." In her brief, she now says that the EEOC investigator said "something had happened" and "you have been terminated." Although she now claims in her brief that this is based on personal knowledge, she admitted that her knowledge as to this issue was only based on what the EEOC investigator told her. This is inadmissible hearsay which can not be considered by the Court. *See* F.R.E. 801 and 802; FED.R.CIV.P. 56(e). Plaintiff also relies on the notes of the EEOC investigator and the right to sue letter. However, the EEOC notes in question are simply notations of statements made by Plaintiff, and are nonetheless inadmissable hearsay. *See id.* Further, the right to sue letter states that the EEOC is unable to conclude that the information obtained established any discrimination. Lastly, Plaintiff attributes a statement to Annette Frazier from Delta Airlines whereby she allegedly stated "there was no record of Dana Mehen being employed at Delta . . . " However, as Delta correctly argues, this is hearsay to which no exception applies because there is no evidence that Annette Frazier was a Delta manager, that she was authorized to make such a statement relating to

termination, and such a statement was within the scope of her duties at Delta. *See* F.R.E. 801, 802, 801(d)(2); FED.R.CIV.P. 56(e).

Lastly, Defendant correctly argues that Plaintiff has claimed since 1994, and continues to claim today that she is totally disabled and unable to perform any work whatsoever; as such, even if Plaintiff had been terminated, Delta is not liable under the ADA as she is not a "qualified individual" under the ADA and it had no legal obligation to allow her to remain on indefinite leave. *See Kaplan v. City of North Las Vegas*, 323 F.3d 1226, 1230 (9th Cir. 2003) (a person is entitled to protection under the ADA only if is she is a "qualified individual" which means that the employee can perform the essential functions of the job with or without reasonable accommodation); *Wood v. Green*, 323 F.3d 1309 (11th Cir. 2003) (employer was entitled to terminate employee as indefinite leave is not required by the ADA);[2] *Boykin v. ATC/VanCom of Colorado, L.P.*, 247 F.3d 1061, 1064 (10th Cir. 1999) (reasonable accommodation does not require an employer to place an employee on indefinite leave).

---

[2] Plaintiff seems to suggest in her brief that there may be a claim for failure to accommodate. However, she never made a failure to accommodate claim in her Amended Complaint, and there is no evidence that she actually requested or Delta received a request to accommodate after her LTD benefits were eventually denied in September of 2000. Rather, it is undisputed Plaintiff has claimed since 1994 that she is totally disabled and unable to perform any work.

2. Disability Discrimination-Harassment/ Hostile Work Environment

Although the Ninth Circuit has not expressly recognized a harassment claim based on disability, other federal appellate courts have treated such a claim under the same standard for a hostile work environment claim under Title VII. *See Silk v. City of Chicago,* 194 F.3d 788, 804 (7th Cir. 1999); *Keever v. City of Middletown,* 145 F.3d 809, 813 (6th Cir. 1998). Thus, as applicable to this case, a prima facie case for a hostile work environment based on disability, Plaintiff must show: "(1) [s]he was subjected to verbal or physical conduct [based on her disability]; (2) that the conduct was unwelcome; (3) that the conduct was sufficiently severe or pervasive to alter the conditions of plaintiffs employment and create an abusive work environment." *Gregory v. Widnall*, 153 F.3d 1071, 1074 (9th Cir. 1998). The conduct in question must be both subjectively hostile to the Plaintiff and objectively hostile from the viewpoint of a reasonable person in Plaintiff's position. *See Nichols v. Azteca Restaurant Enterprises, Inc.,* 256 F.3d 864, 871-872 (9th Cir. 2001). The required level of severity of the work environment "varies inversely with the pervasiveness or frequency of this conduct." *Id.* Whether a work environment is hostile under this standard can only be "determined only by looking at all the circumstances. These may include the frequency of the discriminatory conduct; its severity; whether it is physically threatening or humiliating, or a mere offensive utterance; and whether it unreasonably interferes with an

employee's work performance." *Harris v. Forklift Systems, Inc.*, 510 U.S. 17, 23 (1993).

As a threshold matter, a review of Plaintiff's deposition and response to Delta's motion for summary judgment shows that many of her claims of harassment are based on the alleged actions of the ERISA Defendants. As Delta correctly argues – the denial of her ERISA LTD benefits, telephone calls requesting additional information relating to her LTD claims and COBRA claims, surveillance[3] of Pat Higgins enlisted by the ERISA Defendants to assess her physical limitations, failure to pay certain medical bills, denial of her request to continue under COBRA, etc. – are all actions which are not attributable to Delta. Rather these were actions taken, by or on behalf of the LTD Plan and Medical Plan. As the Court has already ruled that these are separate legal entities in relation to these issues, Plaintiff can not claim harassment on the part of Delta for these actions. In addition, as to the denial of benefits at issue in this case (LTD benefits and COBRA), the Court notes that it has already found that these benefits were properly denied.

Plaintiff also argues that Delta has harassed her through the use of "thugs" coming to her house, many

---

[3] The LTD Plan enlisted an investigator to make a videotape of Plaintiff while she was in public to assess the scope of her physical limitations. Nevertheless, as expressly stated by the Administrative Committee, this was not relied upon in affirming the denial of LTD benefits.

anonymous phone calls at all hours of the night, and various other people coming to her house. Specifically, Paragraph 26 of her "Statement of Fact" states:

> Mehen has been harassed since her disclosure to Delta Airlines INC. in 1997 that she was a disabled individual. (Exhibits 41, 42, 43, 44, 45). There have been vehicles parked at the entrance to Mehen's, they have been seen driving by Mehen's residence at all hours of the day and night and vehicles have attempted to crash Mehen's front gate. There have also been anonymous phone calls originating in Atlanta, Georgia the headquarters for Delta Airlines INC. and the ERISA defendants, other calls asking question about Mehen."

A review of these exhibits submitted in support these allegations shows that Mehen has no evidence whatsoever showing that Delta was involved. Mehen has no evidence of who any of these "thugs" were, or who any of the people who passed by or came to the house were as well. As to the phone calls, because they originated from Atlanta, Georgia she assumes that all of these calls were from Delta because it is based in Atlanta. However there is no actual evidence that these calls were actually from Delta. Rather, a review of the exhibits in question shows that Plaintiff's claims that Delta was involved is based on pure speculation.

Plaintiff also claims in her responsive brief that callers identifying themselves as Delta employees

attempted to get information from her children, asking such questions as "Do you think mommy can work?" and "Does mommy have a new job?." However, as Delta correctly points out, Mehen's deposition testimony reveals that such phone calls were from Delta's attorneys in relation to the litigation at issue, and that such contact from attorneys can not properly be considered harassment attributable to Delta. Further, to the extent that Delta employees asked questions attempting to gain information about Plaintiff's prognosis it relation to her ability to work, such conduct does not arise to the level of an ADA violation. *See Miranda v. Wiscconsin Power & Light Co.,* 91 F.3d 1011, 1017 (7th Cir. 1996). Further Delta opposing Plaintiff's workman's compensation claim was not improper, as even Plaintiff admits that Delta was entitled to take such action under California law.

A review of the record in this case shows that Plaintiff has failed to create a genuine issue of fact that Delta's actions were sufficiently severe or pervasive to alter the conditions of plaintiff's employment and create an abusive work environment. *See Gregory,* 153 F.3d at 1074. Further, as Delta correctly argues, Plaintiff has not performed any work for Delta since 1994. Plaintiff's allegations of harassment arose years after she stopped performing any work for Delta and none of the alleged harassment occurred at work. Thus, there is no evidence and no issue of fact that her work conditions were altered or that an abusive work environment was created as Plaintiff has not been in a Delta work environment

since 1994 which was before any allegations of harassment actually arose. *See id.* Accordingly summary judgment is granted in favor of Delta as to Plaintiff's claims of discrimination pursuant to the ADA. Lastly, the Court notes that it does not appear that Plaintiff's amended complaint has asserted an ADA discrimination claim against the ERISA Defendants. Further, the ADA requires an employee to file a charge of discrimination against a defendant prior to filing a suit against them; here, it is undisputed that Plaintiff's charge of discrimination failed to name the ERISA Defendants in her charge of discrimination. *See* 42 U.S.C. §12117(a) (adopting charge filing requirement in ADA from 42 U.S.C. §12117); *Santa Maria v. Pacific Bell,* 202 F.3d 1170, 1176 (9th Cir. 2000) (charge filing requirement applies in ADA cases); 42 U.S.C. §2000e-5(f)(1) (right to file civil suit against "against the person named in the charge"). Accordingly, to the extent Plaintiff asserts an ADA claim against the ERISA Defendants, summary judgment is granted in favor of the ERISA Defendants on this claim.

C. ERISA Defendants' Counterclaim – Overpayment

Lastly, the ERISA Defendants argue that the benefits due under the Disability and Survivorship Plan are subject to an offset for Social Security benefits received by Plaintiff. The ERISA Defendants are claiming that the LTD Plan made an overpayment to Plaintiff because the Social Security Administration

determined her to be disabled and entitled to benefits effective December 1, 1994. After this date, her monthly Social Security benefit exceeded the amount of her Plan benefit resulting in a overpayment to Plaintiff of $21,197.98, which the ERISA Defendants are seeking to obtain from Plaintiff. However, the ERISA Defendants are not entitled to summary judgment on this claim due to insufficient facts and citation of authority supporting this claim. As to the ERISA Defendants' argument that benefits are subject to an offset, they rely on Statement of Fact ("SOF") Paragraph 3 cites to Exhibit 1A at DP41 which apparently refers to section 7.02(b)(ii) of the LTD Plan which states: "The amount of benefits described in each option above shall be reduced by the amount described in paragraphs (b), (c), (d), (e) and (f) of section 7.01 of the Plan." Although Exhibit 1A includes various excerpts of the LTD Plan, section 7.01 (which presumably discusses various offsets) is not included in Exhibit 1A for the Court's review. In addition, to support their claim for $21,197.98, the ERISA Defendants only attach various handwritten notations and fill in the blank forms. *See* SOF ¶13. However, the ERISA Defendants have not submitted an affidavit, deposition testimony, or similar evidence explaining in detail how the $21,197.98 amount was reached. Lastly, in regards to the ERISA Defendants claim for overpayment in both their initial motion for summary judgment and reply brief, they cite no legal authority entitling them to reimbursement of the $21,197.98 from Plaintiff. *See* ERISA Defendants Motion for Summary Judgment at 17 and Reply Brief at 10.

Local Civil Rule 7.2(c) requires a party to set forth "points and authorities relied upon in support of the motion." Local Civil Rule 7.2(i) states that substantial noncompliance with Local Rule 7.2 may be deemed a consent to summarily denying the motion. Accordingly, as there are insufficient facts and authority to support the ERISA Defendants' argument, the ERISA Defendants Motion for Summary Judgment as to the claim for overpayment is denied.

IV. CONCLUSION

Accordingly, IT IS HEREBY ORDERED as follows:

(1) The ERISA Defendants' Motion for Summary Judgment seeking to dismiss Plaintiff's claims is **granted**;

(2) Delta's Motion for Summary Judgment is **granted**;

(3) The ERISA Defendants' Motion for Summary Judgment on their counterclaim is **denied**;

(4) In light of these rulings, the ERISA Defendants' counterclaim is the only remaining claim in this case. Pursuant to the Court's Scheduling Order, if the ERISA Defendants wish to proceed to trial on the counterclaim, the Joint Pretrial Statement and Motions in Limine are due within 30 days of the filing date of this Order. Alternatively, the parties may file a stipulation for dismissal, or engage in a settlement conference with a Magistrate Judge at no cost to the parties.

DATED this 4th day of May, 2005.

/s/ Cindy K. Jorgenson
Cindy K. Jorgenson
United States District Judge